

GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE DEPUTY MAYOR FOR EDUCATION
OFFICE OF THE DEPUTY MAYOR FOR HEALTH AND HUMAN SERVICES



SUMMARIZED FINDINGS AND RECOMMENDATIONS:

*REVIEW OF INTERACTIONS WITH RR AND HER
IMMEDIATE FAMILY
AND
DISTRICT GOVERNMENT AGENCIES*

SEPTEMBER 2, 2014

Preface

The report that follows is based on a comprehensive case review of the involvement of District of Columbia (the District) Government health and human service agencies, schools and contracted providers with RR and her family. The review was undertaken by the Deputy Mayors for Health and Human Services and Education (the Deputy Mayors) at the request of Mayor Vincent C. Gray following the disappearance of RR.

The safety and well-being of any child is ultimately the responsibility of his or her parents or legal guardians and family. At the same time, the government's mission and mandate is to intervene, when necessary, to support families and protect children. The purpose of the review was to assess all of the facts surrounding the District's involvement with this family, to determine whether the District's health and human service agencies and DCPS followed internal policies and procedures in providing services to RR and her family and to make policy and programmatic recommendations if warranted. Even if all of the policy and practice recommendations in this report had been in place and fully implemented, the Review Team did not find evidence that these tragic events were preventable.

On March 19, 2014, staff at Payne Elementary School reported to _____ that RR, an 8-year-old student at the school, _____ At the time of her disappearance, RR was a resident of the _____ (_____) family shelter where she lived with her mother, SY, her three (3) brothers and her mother's boyfriend, AW (father of RR's two youngest brothers). RR's disappearance triggered an Amber Alert and a criminal investigation by the Metropolitan Police Department (MPD) and the Federal Bureau of Investigation (FBI). The criminal investigation quickly focused on Khalil Tatum, a _____ shelter staff member, and his relationship with RR and her family while at the shelter. During the search for RR and Mr. Tatum, the police discovered Mr. Tatum's wife, Andrea Tatum, shot to death at a hotel in Maryland on March 20, 2014. Two weeks later, on March 31, 2014, Mr. Tatum was found dead from an apparent self-inflicted gunshot wound. RR has not been found and the criminal investigation into her disappearance is ongoing.

On April 8, 2014, the Mayor directed the Deputy Mayors to conduct a review of the contact between RR and her immediate family and the District's human service and education systems and to make recommendations for reforms, if warranted, to the District's policies and practices. The Deputy Mayors convened a Review Team to provide consultation and subject matter expertise to the review process. The Review Team included the agency directors from the Child and Family Services Agency (CFSA), the Department of Behavioral Health (DBH), the Department of Human Services (DHS), and the District of Columbia Public Schools (DCPS). The Review Team also included an external member, Judith Meltzer, Deputy Director at the Center for the Study of Social Policy and the court-appointed monitor for CFSA in *LaShawn A. v. Gray*.

A list of relevant system improvements resulting from this Review as well as from ongoing reform efforts is included in the attached Appendix.

Methodology

Over the course of four (4) months, staff from the Deputy Mayors' offices reviewed the family's files from all four (4) agencies and relevant service providers and interviewed sixteen (16) individuals, including government employees and contractors. Because the review took place within the context of an ongoing criminal investigation, the reviewers did not have access to the information in the criminal investigative file or attempt to interview RR's mother.

Specifically, the information included the following from _____, DBH, DHS and DCPS, and their contracted providers:

- Hard copy and electronic case files consisting of thousands of pages of case notes, assessments, and collateral documentation;
- Policy documents and procedural manuals, with a focus on staffing and supervision, service delivery, quality assurance, and accountability;
- Education records related to the children in this family;
- Job descriptions for relevant staff that have interacted with this family; and
- Public statements, reported in the media, by RR's family and others related to the case.

After reviewing the policy, procedures and case-specific information available through extensive written and electronic records¹, staff members from the Deputy Mayors' respective offices conducted interviews with the following individuals based on interview protocols created in consultation with the Review Team members:

- Case Worker and Supervisor (The Community Partnership (TCP))
- _____
- _____
- _____
- Social Worker (DCPS)
- Community Support Worker and Supervisory (First Home Care Mental Health)
- Director of the Adult & Children Clinical Services Department (Catholic Charities)
- Director (Anchor Mental Health)
- Clinical Manager (Anchor Mental Health)
- Clinical Manager/Assertive Community Treatment (ACT) Team (Anchor Mental Health)
- ACT Team Lead (Anchor Mental Health)

Confidentiality

The District of Columbia is bound by multiple statutes that protect the details of the family's interaction with human service and education agencies from public disclosure. The privacy laws including the Health Insurance Portability and Accountability Act (HIPAA), and its implementing regulations, 45 C.F.R. 164.501 *et seq.*; Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. § 1232g, and its implementing regulations, 34 CFR Part 99; the District of

¹ The Deputy Mayors' staff compiled a comprehensive chronology of the family's interaction with District Government agencies and contractors. All team members individually and collectively reviewed the chronology to fully understand the circumstances surrounding RR's disappearance. In addition, the chronology identified the range of involvement by multiple public and contracted agencies and their staff with this family prior to and since RR's disappearance; gaps in the description of events; places with conflicting information; and areas that required specific follow-up through interviews.

Columbia Mental Health Information Act of 1978 (D.C. Official Code § 7-1201.01, *et seq.*), as amended; Child and Family Services Agency Records, D.C. Official Code § 4-1313.06; the District of Columbia Public Assistance Act of 1982 (D.C. Official Code § 4-209.04), as amended; the Data-Sharing and Information Coordination Amendment Act of 2010 (D.C. Official Code § 7-241, *et seq.*), as amended; the District of Columbia Homeless Services Reform Act of 2005 (D.C. Official Code §§ 4-754.11(7) and 4-754.21(12)) (HSRA), as amended; and any other applicable District and Federal confidentiality and privacy laws.

The Deputy Mayors' records and work product consist primarily of protected education, health and human services information. As a result, it is not practical to include the family's full history and interaction with the District government in this report because the report would be largely redacted and thus unreadable. To the extent possible, the Deputy Mayors have written the report in a manner to minimize the use of protected education and health information and redactions. This is the only report prepared for public dissemination. All other remaining agency records and internal work product remain confidential in accordance with the above-referenced laws and regulations. Accordingly, the Deputy Mayors issue the following "Summarized Findings and Recommendations:"

SUMMARIZED FINDINGS AND RECOMMENDATIONS

Finding #1: This family's case presented a range of challenges (e.g. homelessness, poverty, and history of mental illness) that are not unique among families served by District of Columbia health and human services agencies. The family was receiving services from multiple social service, _____, education and health agencies and community providers. At the time of RR's disappearance, _____, _____'s compliance with _____ and other services was inconsistent; however, the known family circumstances did not satisfy the legal threshold for removal of the children.

Recommendations #1:

1.1. District Government agencies and its contracted providers must develop and implement policies and procedures requiring case workers to review all historical information at their disposal in order to be able to fully assess and document in the case file whether a family is having a onetime issue or presenting a consistent pattern of multi-faceted problems as well as to promptly elevate through the chain of command any issues with assessing or engaging a family in recommended services.

1.2. CFSA and the Office of the Attorney General (OAG) should establish a policy and train social workers on the criteria and protocols for when it is appropriate to involve the D.C. Superior Court in providing judicial oversight on in-home child welfare services when a family is not making adequate progress despite the offer of services.

Finding #2: From September 2013 through March 2014, the Deputy Mayors found that multiple human service agencies ([redacted], DBH, and DHS) and DCPS were engaged with the family. The agencies knew of the involvement of the other agencies but did not consistently share information or consistently convene inter-agency team meetings with case managers at these agencies; nor did they seek the consent of each family member to share their information with the providers. Therefore, information about the family's strengths and needs known by one agency was not fully communicated to others and the interventions were not coordinated.

Recommendations for Finding #2:

2.1. CFSA, DBH, and DHS should conduct a review of their internal policies and practices, and modify as necessary, to ensure that assessments and treatment planning for families with multiple members involved in care are done in close coordination with the human service providers treating other immediate family members. When information cannot be shared without written authorization under an applicable confidentiality law, the agencies policies and practices should encourage the routine request for consent from the affected family members.

2.2. A cross-agency working group charged with creating the best structure for identifying the District's families with the most complex needs and a strategy for coordinating services across all relevant agencies should be formed. The work group should identify national best practices and predictable analytics for identifying families most in need. In addition, this group should formulate a common approach to client engagement, teaming, assessment, planning, intervening and tracking and adjusting across all human service agencies.

Finding #3: In March 2014, DCPS attempted to obtain from SY medical documentation justifying RR's [redacted]. SY informed DCPS that RR was sick and that she was under the care of a Dr. Tatum. When DCPS attempted to obtain medical documentation from Dr. Tatum at the family shelter, the school social worker discovered that Mr. Tatum was not a doctor. The school social worker promptly reported the matter to [redacted] in accordance with the District's mandatory reporting responsibilities. By that time, RR [redacted] over the course of the school year. DCPS staff reported that they delayed making an earlier referral to CFSA (required to occur within two business days after 10 unexcused absences) to allow RR's mother additional time to collect the medical documentation required to justify RR's absence from school.

Recommendation for Finding #3:

3.1. It is recommended that DCPS clarify and standardize the reporting requirements under D.C. truancy law so that each school is reporting in strict compliance with the law. This includes reviewing and training schools on policies on excused v. unexcused absences and verification and documentation requirements. DCPS should create policy that defines what constitutes "excessive excused absences," triggering further action on the part of the school.

Finding #4: TCP conducted a pre-employment criminal background check on Mr. Khalil Tatum. Despite prior felony convictions for burglary and breaking and entering, D.C. law did not prohibit Mr. Tatum from working at the [redacted] family shelter in close quarters with its residents. Mr. Tatum was screened for his position consistent with the requirements of current law and was not in a safety sensitive position as defined by the Child and Youth, Safety and Health Omnibus Amendment Act.

Recommendations for Finding #4:

4.1. All job applicants for positions which may bring them in contact with minor children, and employees, should be screened using the Child Protective Registry list. Therefore, it is recommended that the Deputy Mayors work with the D.C. Council to revise the Child and Youth, Safety and Health Omnibus Act of 2004 to include screening of the Child Protective Registry for all staff members who may interact with minor children, including all staff who work at shelters involving families.

4.2 Within thirty (30) days of the Council's return from recess, the Executive should submit any legislative proposals to strengthen applicable policies or practices referenced herein.

Finding #5: TCP has a Fraternalization policy which prohibited relationships between staff and residents. Khalil Tatum signed the policy. Mr. Tatum violated this policy with his interactions with RR and her family. Following RR's disappearance, shelter staff acknowledged that Mr. Tatum had a relationship with RR and her family in violation of the Fraternalization policy. The Fraternalization policy did not require employees to report violations of the policy by other employees to the shelter administrators.

Recommendation for Finding #5:

5.1. Within thirty (30) days, TCP shall provide evidence of changes in policy and procedures so that shelter employees are required to report any information or knowledge that they have about other employees' pre-existing or new personal relationships with shelter residents to appropriate supervisors and that such reports are documented in writing and tracked as unusual incidents. It is recommended that TCP ensure that the shelter providers investigate the reports and document in writing actions taken in response.

Finding #6: Many of the families at the [redacted] family shelter have very complex needs beyond the homeless services DHS provides through its contract with TCP. The current contract with TCP provides that the role of the caseworker is focused on identifying housing options for the families living in the family shelter, versus augmenting or reinforcing the clinical case management provided by other external providers. Furthermore, the caseworker position description did not require a licensed clinical social worker and the shelter staff did not receive clinical supervision on engaging with families with complex needs. In an environment such as the family homeless shelter, a higher clinical expertise and adequate clinical supervision is necessary to increase the effectiveness of case management.

Recommendations for Finding #6:

6.1. Increase the number of on-site case managers to identify and engage those families who are difficult to serve and who do not follow through with services and support needed to help them increase stability, gain employment and regain more permanent housing. Additionally, ensure that appropriate and consistent clinical supervision is in place at the [redacted] shelter.

6.2. Locate CFSA in-home services social workers at [redacted] shelter given the high numbers of families at the [redacted] shelter who have current or prior involvement with CFSA.

Finding #7: There were several instances in the provider records where professionals mandated to report known or suspected instances of child abuse or neglect, expressed concern about the safety and well-being of the children but failed to act. In some instances, case workers stated that they did not report their concerns to the CFSA hotline because they knew that [redacted].

Recommendations for Finding #7:

7.1. Provide additional annual mandated reporter training to [redacted] Staff, DCPS social workers and mental health providers (both adult and child) in order to improve understanding of how to most effectively fulfill their responsibilities.

7.2. DHS, DCPS and DBH will ensure that all contractors have all their staff trained and monitor enforcement and will terminate any contractor in violation of this requirement.

Finding #8: The review found limited interventions to address the [redacted] allegations between [redacted] and [redacted] or their alleged [redacted].

Recommendation for Finding #8:

8.1 DHS, DBH and CFSA need to strengthen policy and practice guidance and training for staff on how to appropriately identify and address [redacted] within families. DHS, DBH and CFSA need to develop referral guidelines for connecting families with [redacted] as part of the family's unified case plan.

Finding #9: [redacted] received appropriate and timely mental health interventions [redacted]. The provider's initial diagnostic assessment acknowledged [redacted] current living situation and the risk assessment evaluated traditional risk factors such as homicidal and suicidal ideation but did not specifically consider [redacted] environmental risks inherent in living in a homeless family shelter environment, including living in close quarters with strangers and risks to physical health and hygiene.

Recommendation for Finding #9:

9.1. DBH should evaluate its risk assessment policies to determine whether providers are fully evaluating and considering all of the environmental risk factors confronting individuals, particularly youth, living in a homeless family shelter setting, and develop appropriate interventions to mitigate risk. It is recommended that DBH standardize the risk assessment requirements through regulation or policy.

Finding #10: [redacted] provided [redacted] a housing subsidy from 2006 through 2012. On three (3) separate occasions, [redacted] were evicted for non-payment of their portion of the rent and for other serious housing violations. In the fall of 2013, as a condition of receiving another [redacted] housing voucher, [redacted] required that [redacted] appoint a representative payee responsible for paying [redacted] rent. [redacted] refused to appoint a representative payee until December 2013, substantially delaying [redacted] ability to receive another voucher. The [redacted] regulations permit an application for a representative payee when an individual is not able to responsibly manage the benefit payments.

Recommendation for Finding #10:

10.1. [redacted] should review its representative payee policies and develop clear criteria when a representative payee is required for a family with frequent evictions and under what circumstances providers should apply directly to the [redacted] rather than wait for client consent.

Finding #11: At the time of RR's disappearance, both [redacted] were providing services to the family; however, there was no recent assessment of RR's parents' capacity or of the family's overall functioning.

Recommendations for Finding #11:

11.1. District Government agencies and their contracted providers should ensure that client/family assessments are current and take into account broader family functioning to include economic security, living conditions and environmental risk factors.

11.2. CFSA should continue its current work to expand and improve implementation of evidence-based practices used to assess safety and risk with ongoing cases and its quality improvement efforts regarding risk assessments, safety planning and decisions about safe case closure.

Finding #12: Case documentation was frequently repetitive from interaction to interaction or did not contain enough detail to allow new staff to quickly and comprehensively understand the family's history and circumstances.

Recommendation for Finding #12:

12.1. The District's human services agencies should standardize documentation requirements across all District government health and human service agencies, schools and contracted providers. Family-serving workers throughout the city should adhere to the same standards for complete and timely documentation of client assessments, case planning and contacts, and should have access within the bounds of confidentiality laws to each other's documentation.

Finding #13: During the time this family was residing at the [redacted] family shelter, one or more of the children were often absent in the evening. While parents may make other arrangements for their children, e.g. to stay with relatives, to minimize the amount of time the children stay at the family shelter, the documents indicate that all four (4) children were present in the family shelter for less than 50% of the time that the children resided there with their parents. During the nightly checks verifying the presence of children – a requirement to reside in the family shelter – TCP did not accurately determine whether the children were present and did not identify children by name, rather staff listed only the number of children present.

Recommendations for Finding #13:

13.1. DHS should require its contracted shelter operators to conduct and document nightly accounting of whether the children are residing in the family shelter. DHS should develop policies and protocols outlining the appropriate use of the information gathered from the nightly census, as part of developing a more robust shelter case management practice.

Finding #14: The school officials experienced difficulty getting the information they needed to fully understand the children's and family's needs.

Recommendations for Finding #14:

14.1. DCPS should review the current information captured in their data and case management systems and ensure that they are consistently documenting case practice with children and families.

14.2. All District Local Education Agencies (LEAs) should develop policies clarifying how and when school staff must record interactions with students and their families and monitor records for compliance.

14.3. All District LEAs should review the range of services and social supports that need to be available, particularly in schools with high concentrations of homeless children and make necessary staffing and resource commitments.

14.4. All District LEAs must ensure that student records related to attendance/truancy and other pertinent information from closed schools are promptly transferred and/or available to “receiving” schools.

Finding #15: The review reaffirmed that large family shelters are no place to raise children. The Mayor and the District Council are already on record collectively affirming the goal to close [redacted] as a shelter for families who are homeless and to take aggressive and deliberate action to develop alternative housing options for families. RR’s disappearance has focused attention on the urgency of the need for action, -- in the short term to make the [redacted] Shelter a safer place for children and families living there and in the longer term, to eliminate the need for its continued existence.

Recommendations for Finding #15:

15.1. DHS should ensure implementation of their Memorandum of Understanding with the Department of General Services (DGS) that requires at a minimum that DGS conducts weekly on-site inspection of the shelter facilities, there is a process in place for notifying DGS of building and facility issues and a process for tracking work orders to ensure that they are responded to in a timely manner.

15.2. DHS and contracted shelter operators should increase private security staff inside the shelter and the Protective Services Police Division (PSPD) and MPD officers should increase patrol around the shelter entrance.

15.3. DMHHS, in conjunction with DHS and DGS will transmit a plan by September 30, 2014, to the Mayor detailing the necessary steps with appropriate timelines for developing alternative smaller shelter options for homeless families

Engagement will also continue its work with local universities to secure social worker interns to help support truancy work as needed and utilize supports being provided by the Justice Grants Administration (JGA) to more than 40 DCPS schools.

7. Over the past three years, as a part of the District's Temporary Assistance to Needy Families (TANF) reform, DHS has developed a unified case planning model that uses the DHS TANF redesign as the overarching framework for unifying the case plans of families receiving TANF, family homeless services, and potentially other agency services and supports. To accelerate the development of a truly unified approach to serving families, CFSA, in collaboration with DHS has engaged a contractor, Matric Human Services, to advise them on unified case planning models and make recommendations for how CFSA and DHS can develop a unified case plan for families receiving both child welfare services and TANF.
8. DHS has created a position that will be responsible for leading and developing key aspects of the expansion of the TANF/Homeless Services integration both within DHS and across all Health and Human Services agencies and is in the process of hiring for that position. Concurrently, DBH is evaluating whether changes to its risk assessment policies and practices are necessary to incorporate family living conditions, and environmental risks.
9. DHS has implemented an evidence based-functional assessment tool, the Service, Prioritization, Decision, Assistance Tool (SPDAT) for families who are receiving homeless services and the TANF Comprehensive Assessment for all families TANF.
10. Over the past year, CFSA, DBH, and the Department of Youth Rehabilitation Services (DYRS), have been working together to implement the Child and Adolescent Functional Scale (CAFAS), a nationally recognized tool for assessing child-youth day-to-day functioning across several life domains and determining whether it is improving over time. The goal is to implement the CAFAS across all child-serving agencies and in schools for youth with an Individualized Education Plan (IEP). These actions position the District to take the next steps toward developing and having the full range of human service agencies use a standardized assessment tool that can provide a comprehensive understanding of the day-to-day functioning of individual members of a family and the family as a unit in order to inform decisions about level of care, type and intensity of treatment and the need for referrals to other systems.
11. CFSA is currently reviewing how to best assess family functioning and improve the tools that social workers use to gauge parent-caregiver attributes and needs. When combined with results from the CAFAS assessment of children and youth, social workers will have added skills and tools to inform their work with families.
12. Another important change underway at CFSA is its adoption of the RED (Review, Evaluate and Direct) Team model since February 2013. The RED Team model brings together professionals from several disciplines to go through a structured process that guides critical thinking at key decision points throughout a case. DBH staff that are co-located at CFSA have been a part of this process since its inception.